DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/22/11

PRINTED: 03/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445296	A. BUILDING _____ B. WING _____	03/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF EAST RIDGE	1500 FINCHER AVENUE EAST RIDGE, TN 37412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation numbers 27227, 27443, and 27631 were completed during the annual Recertification Survey at Life Care Center of East Ridge on March 6-8, 2011. No deficiencies related to the complaints were cited under 42 CFR PART 483.13, Requirements for Long Term Care.	F 000	This Plan of Correction constitutes our written allegation of compliance. "This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This Plan of Corrections does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope of severity regarding any of the deficiencies cited are correctly applied."	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to implement an individualized toileting plan for one resident (#2) and failed to obtain a physician's order and medical justification for a urinary catheter for one resident (#1) of twenty-three residents reviewed. The findings included: Resident #2 was admitted to the facility on December 17, 2010, with diagnoses including Cerebrovascular Accident with Right Hemiplegia, Hypertension, and Senile Dementia.	F 315	1. An individualized toileting plan was developed for resident #2 by nursing administration. A physician's order was obtained for bladder training, then remove catheter for resident #1 by nursing administration staff on 3/8/11.	4/5/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

EL 3/16/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 315	Continued From page 1 Medical record review of the Admission Minimum Data Set dated December 24, 2010, revealed the resident was able to complete the interview, and was frequently incontinent of bladder. Medical record review of a physician's order dated December 20, 2010, revealed, " ...prompted toileting upon awakening, before meals, at HS (bedtime), (and) prn (as needed)..." Medical record review of the Assessment for Bowel and Bladder Training dated December 24, 2010, revealed the resident was a candidate for toileting, timed or scheduled voiding. Medical record review of the Urinary Incontinence Assessment dated December 24, 2010, revealed, "Can the resident comprehend and follow directions? Yes...Can the resident learn to control the urge to void? yes ...Perform a 3-day Bladder Flow Record to Assist With Choice of Program-Then complete the Following: Based on the 3-day Bladder Pattern Assessment, the resident is a candidate for the following program (no programs checked)..." Medical record review revealed no documentation of a 3-day voiding pattern. Review of the policy Bowel and Bladder Training revealed, "...Observe and record the resident's voiding pattern to assist in establishing a training schedule...The...bladder training program must be evaluated and adjusted every few days until a pattern has been established..." Observation on March 7, 2011, at 12:40 p.m., revealed the resident sitting in a wheelchair eating	F 315	2. All other residents were audited by the nursing administration staff to ensure that residents with catheters had a physician order and residents that required a toileting plan had one implemented. 3. An educational inservice was conducted on 3/15/11 by nursing administration to the nursing staff on ensuring that a physicians order has been obtained for catheter use and the policy for toileting plan implementation. A nursing administration member will audit all new admissions daily for four weeks then at least weekly for three months to ensure physician orders have been obtained for catheter use and toileting plans implemented when necesary. 4. The Director of Nursing will report audit results to the Quality Assurance Committee monthly consisting of the Medical Director, Director of Nursing, Administrator, Social Services, Pharmacist and other interdisciplinary team members for further recommendations, if needed. The Administrator will monitor to ensure continued compliance.	

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F 315	Continued From page 2 lunch, in the resident's room. Interview on March 7, 2011, at 10:50 a.m., with Registered Nurse (RN) #1, in the Director of Nursing office, confirmed no individualized toileting schedule had been established for the resident. Resident #1 was admitted to the facility on January 18, 2011, and readmitted on February 22, 2011, with diagnoses including Left Above the Knee Amputation, Peripheral Vascular Disease, Peripheral Arterial Disease, Pneumonia, and Senile Dementia. Medical record review of the Admission Minimum Data Set dated January 25, 2011, revealed the resident was frequently incontinent of bladder. Observation on March 6, 2011, at 9:54 a.m., revealed the resident lying on the bed, with a urinary catheter draining yellow urine. Medical record review of the March 2011, physician's recapitulation orders revealed no physician's order for a urinary catheter. Medical record review revealed no assessment or medical justification for the urinary catheter. Interview on March 6, 2011, at 2:15 p.m., with the Assistant Director of Nursing, in the conference room, confirmed there was no physician's order, and no assessment or medical justification for the urinary catheter.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		4/5/11

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F 323	Continued From page 3 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility investigation, and interview, the facility failed to ensure safety devices were in place to prevent falls for two residents (#14, #5) resulting in harm from a humerous fracture (upper arm) and a head laceration for one resident (#14) of twenty-three residents reviewed. The findings included: Resident #14 was admitted to the facility on January 3, 2011, with diagnoses including Femur Fracture, Subarachnoid Hemorrhage, Intracranial Hemorrhage, Chronic Obstructive Pulmonary Disease, Anemia, Hemiplegia Dominant Side, Aphasia, Seizure Disorder, and Gastrointestinal Bleed. Medical record review of a nurse's note dated January 3, 2011, revealed "...hx (history) fx (fracture) (R) (right) hip after fall in yard...also had a traumatic small frontal subarachnoid hemorrhage & (and) potential intraparenchymal hemorrhage in the frontal region...hx of CVA (stroke) x (times) 3 with chronic expressive aphasia and (R) hemiparesis with progressive dementia...poor short term memory..."	F 323	1. Resident # 14 had a pressure sensitive alarm and a regular mattress with floor mats beside the bed placed by the nursing staff on 3/8/11. Resident #5 had pressure sensitive alarm attached by the nursing staff on 3/6/11. Care Plans for resident # 14 and #5 have been updated by the nursing staff. 2. All residents were audited by the nursing administration staff to ensure pressure sensitive alarms and bolster pads were in place, if ordered, on 3/8/11.	

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F 323	Continued From page 4 Medical record review of the nurse's notes dated January 3, 2011, through January 12, 2011, revealed the resident had "...poor short term memory ...required maximum assistance with all activities of daily living...incontinent of bowel and bladder...confused...restless (at night)...climbing out of bed..." Continued medical record review of the nurse's notes revealed the use of a low bed, half side rails, a tab alarm in bed and wheel chair, and receiving Physical and Occupational therapy. Medical record review of a fall risk assessment dated January 4, 2011, revealed a score of 22 (10 or higher is at risk). Review of a facility investigation dated January 13, 2011, at 7:00 p.m., revealed "...CNA (certified nursing assistant) doing rounds...observed pt. (patient) lying supine on floor next to bed...pt. attempted to get OOB (out of bed) without assist...fell to floor..." Continued review of the facility investigation revealed "...pressure sensitive alarm to bed & (and) W/C (wheelchair)..." Review of a facility investigation dated January 14, 2011, at 8:00 p.m., revealed "...Nurse responding to pt. yelling out observed pt. lying on floor beside bed...pt. attempted to get OOB without assist, alarm disabled by pt ...no injury..." Continued review of the facility investigation revealed "...Bolster mattress to bed...non-skid footwear PRN (as needed)..." Review of a facility investigation dated January 22, 2011, at 3:00 a.m., revealed "...CNA doing rounds...observed resident lying on (R) side...(R) arm under body...laceration to back of head...resident was on gym mat beside bed...had	F 323	3. An educational inservice was conducted on 3/15/11 by the Director of Nursing or designee for the nursing staff regarding the importance of ensuring pressure alarms and bolster pads are in place correctly and observed daily. The nursing management staff will further review resident falls, if any, each morning (at least five days a week) with the interdisciplinary team, to ensure appropriate interventions have been established. The nursing administration staff will conduct 100% resident fall intervention observation audits at least five days a week for four weeks, then at least weekly for three months, specifically for correct application of pressure sensitive alarm pads and bolster pads. Audits will be reviewed by the Director of Nursing or designee at least daily, five times week per week for four weeks, then at least weekly for three months. The Director of Nursing will review audit findings with the Administrator at least weekly for four months to ensure compliance.	

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F 323	Continued From page 5 attempted to get OOB without assist...pressure dressing applied to scalp...resident sent to ER (emergency room) for eval (evaluation) & tx (treatment)..." Continued review of the facility investigation of a handwritten statement by Licensed Practical Nurse #2 (LPN) revealed "...heard a thump...went to investigate on hall...went into room...and observed (resident) lying on floor...right side with right arm behind (resident) and blood coming from right side of head..." Continued review of the facility investigation revealed "...Staff education on placement of safety devices as ordered..." Further review of the facility investigation revealed a record of inservice and "...safety devices must always be in place as ordered...staff must double check & sign safety devices are in place..." Medical record review of a hospital emergency department record dated January 22, 2011, revealed "...3 x (by) 3 cm (centimeter) contusion with 2 cm laceration...no sutures...wound cleaned, bandaged..." Medical record review of the nurse's notes revealed the resident returned to the facility with new orders to "...Keep wound clean..." Medical record review of a physician's progress note dated January 24, 2011, revealed "...Pt. c/o (complained of) (R) rib & (R) shoulder pain...pt. fell 1/22/11, was evaluated in ER then for scalp lac (laceration)...pt's family noted today that pt. grimaced when assisted with transfers...on exam, no deformity or trauma noted to (R) hip & (R) shoulder, however will x-ray both, hold therapy for today...pt. also requests pain medication...nurse will give..." Medical record review of a nurse's note dated January 24, 2011, at 12:45 p.m., revealed "...new orders received (1) x-ray (R) ribs,	F 323	4. The Director of Nursing will report audit results to the Quality Assurance Committee monthly consisting of the Medical Director, Director of Nursing, Administrator, Social Services, Pharmacist and other interdisciplinary team members for further recommendations, if needed. The Administrator will monitor to ensure continued compliance.	

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F 323	Continued From page 6 (R) shoulder...s/p (status post) fall, (2) hold therapy 1/24/11 d/t (due to) fall, pain to (R) shoulder & ribs..." Medical record review of x-rays of the right ribs and right shoulder dated January 24, 2011, revealed "...Acute non displaced oblique fractures of the humeral head...no convincing evidence for right rib fracture..." Medical record review of physician's orders revealed a order for a sling or swath for the right shoulder and an appointment to be made with orthopaedic physician. Medical record review of a nurse's note dated February 1, 2011, revealed the resident was admitted to the hospital for observation for possible gastrointestinal bleed and returned to the facility on February 4, 2011. Review of a facility investigation dated February 4, 2011, at 8:40 p.m., revealed "...staff responding to sounding pressure alarm...observed resident lying on floor beside bed...resident attempted to get OOB without assist ...no injury..." Continued review of the facility investigation revealed a hand written statement and "...resident was heard yelling & tab alarms were going off...I ran in to find (resident) lying on floor between the beds...laying on (resident) arms & tummy..." Continued review of the facility investigation revealed "...bolster mattress added to bed...staff education on safety intervention for return admissions and readmits...mattress being secured from central supply..." Further review of the facility investigation revealed a record of in-service dated February 7, 2011, and "...all residents re-admitted to facility will be re-assessed for appropriate safety interventions & appropriate interventions will be placed & verified by a nurse..."	F 323		

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F 323	Continued From page 7 Review of a facility investigation dated February 7, 2011, at 9:00 p.m., revealed "...nurse responding to sounding pressure alarm observed resident lying on (R) side in front of w/c on floor...resident attempted to rise from w/c without assist..." Continued review of the facility investigation revealed "...self release soft belt placed to w/c with consent from family..." Review of a facility investigation dated February 16, 2011, at 2:20 p.m., revealed "...CNA responding to sounding bed alarm...observed resident slide to floor on to gym mat after attempting to get OOB...no injury..." Continued review of the facility investigation revealed "...non skid footwear PRN...mattress on floor with consent from family..." Medical record review of a physician telephone order revealed "...d/c (discontinue) non skid footwear at all times...non skid footwear PRN...mattress on floor per family consent...d/c ½ siderails...d/c low bed..." Review of a facility investigation dated February 21, 2011, at 6:00 p.m., revealed "...staff responding to sounding alarm & pt. yelling out...observed pt. lying on gym mat beside mattress on floor...head lying on floor off of gym mat...raised area noted to side of head...pt. rolled off of bed & onto gym mats & struck head on floor..." Continued review of facility investigation revealed "...order for trial safety helmet, gym mats applied to remaining floor space, furniture moved away from pt. bed area..." Further review of the facility investigation of a note added on February 28, 2011, revealed "...pt. refused to wear helmet..." Medical record review of the nurse's notes dated	F 323		

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F 323	Continued From page 8 February 22, 2011, through March 6, 2011, revealed the resident had had no further falls. Observation on March 6, 2011, at 9:25 a.m., revealed the resident lying on a mattress on the floor, pressure alarm in place, and gym mats on each side of the mattress and covering half of the floor of the room Observation on March 7, 2011, at 2:30 p.m., revealed the resident lying on a mattress on the floor with eyes closed. Continued observation revealed a pressure alarm in place and gym mats on each side of the bed and covering over half of the floor in the room. Interview with a family member at the time of the observation revealed the resident had experienced a fall at home resulting in a hip fracture and had been admitted to the facility for aftercare and therapy. Continued interview revealed the resident had experienced several falls since admission to the facility requiring the mattress to be on the floor with the gym mats covering most of the room. Further interview revealed the resident had refused to wear a soft helmet and will "...take it off as soon as it's put on..." Interview with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) Unit Manager #1 on March 8, 2011, at 10:15 a.m., in the DON's office confirmed the resident experienced falls on January 13, 2011, and January 14, 2011, while attempting unassisted transfers. Continued interview confirmed a pressure alarm had been placed on January 13, 2011, and a bolster mattress had been placed after the fall on January 14, 2011. Further interview confirmed on January 22, 2011, the resident attempted to get out of bed unassisted and fell resulting in a	F 323		

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F 323	Continued From page 9	F 323		

laceration to the scalp and a non-displaced fracture of the right humerous. Interview confirmed the pressure alarm had not been in place at the time of the fall to alert staff of the resident's attempt to get out of bed and resulted in a fracture of the humerous and a laceration to the scalp requiring a transfer to the emergency department for treatment. Continued interview confirmed the resident was admitted to the hospital on February 1, 2011, and had returned to the facility on February 4, 2011. Interview confirmed on February 4, 2011, the resident experienced a fall from the bed. Continued interview confirmed the facility had failed to place the bolster mattress in place after return from the hospital.

Interview by telephone on March 8, 2011, at 1:00 p.m., with LPN # 2 confirmed LPN #2 was assigned to the resident on January 22, 2011, when the resident attempted to transfer unassisted and fell to the floor. Continued interview confirmed at the time of the fall the pressure sensitive pad on the resident's bed was not attached to the alarm box and the alarm box was still on the resident's wheelchair resulting in the failure of the box to sound to alert staff of the resident attempting to get out of bed.

Resident #5 was admitted to the facility on December 12, 2010, with diagnoses including Acute Pancreatitis, Convulsions, Diabetes Mellitus Type II, Neuropathy in Diabetes, Difficulty Walking, and Muscle Weakness.

Medical record review of the Fall Risk Assessment revealed, "...Total Score...A resident who scores a 10 or higher is at risk..." Continued review of the Fall Risk Assessments dated

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F 323	Continued From page 10 December 31, 2010 (total score 16), January 4, 2011 (total score 18), January 5, 2011 (total score 18), January 8, 2011 (total score 22), and January 14, 2011 (total score 22), revealed the resident was at high risk for falls. Medical record review of the Care Plan dated January 7, 2011, revealed, "...pressure sensitive alarm to bed..." Review of facility documentation revealed the resident had five non-injurious falls from December 31, 2010, through January 14, 2011. Observation on March 6, 2011, at 9:50 a.m., revealed the resident lying on the bed asleep, with the pressure sensitive pad alarm on the bed under the resident and the alarm box lying on the bed. Continued observation revealed the connecting end of the cord from the pressure sensitive pad alarm was lying on the floor and not connected to the alarm box. Interview on March 6, 2011, at 9:55 a.m., with Licensed Practical Nurse (LPN) #6, in the resident's room, confirmed the facility failed to ensure the pressure sensitive bed pad alarm was connected.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334	1. Resident #3 was discharged from the center on 3/6/11. 2. The nursing administration staff conducted an audit of all other resident's chart to ensure that a influenza vaccine had been administered or declined.	4/5/11

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F 334	Continued From page 11 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of	F 334	3. The Staff Development Director conducted an educational inservice for the nursing staff on 3/15/11 regarding the center's policy on influenza vaccine administration and declination, if desired. The nursing administration staff will review all new admissions chart at least five days a week for four weeks, then at least weekly for three months to ensure that the influenza vaccine had either been given or declined by the resident or responsible party. These audits will be given to the Director of Nursing at least weekly for three months to ensure continued compliance. 4. The Director of Nursing will report audit results to the Quality Assurance Committee monthly consisting of the Medical Director, Director of Nursing, Administrator, Social Services, Pharmacist and other interdisciplinary team members for further recommendations, if needed. The Administrator will monitor to ensure continued compliance.	

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F 334	Continued From page 12 pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to document administration or declination of the influenza vaccine for the 2010 influenza season for one resident (#3) of twenty-three resident's reviewed. The findings included: Resident #3 was admitted to the facility February 16, 2006, with diagnoses including Alzheimer's, Depression, Hypertension, Senile Dementia, Anxiety, and Chronic Pain. Medical record review of the resident TB screening and immunization record revealed the last influenza vaccination administered to resident #3 was on October 16, 2009. Medical record review of a nurse practioner's order and nurses note dated February 25, 2011 revealed the resident tested positive for	F 334		

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F 334	Continued From page 13 Influenza A. Review of a list of residents, provided by the Administrator on March 6, 2011, who received the influenza vaccination for the 2010 and 2011 influenza season, revealed no documentation resident #3 received this immunization. Interview with the Director of Nursing, in the conference room on March 8, 2011, at 9:15 a.m., confirmed the facility failed to document the administration or declination of the influenza vaccination for 2010 and 2011 influenza season.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356	1. The nursing staffing data was corrected and posted on 3/6/11 by the nursing administration staff. 2. The nursing staffing data was observed to be corrected by the Administrator on 3/6/11. 3. The Staff Development Director conducted an educational inservice on 3/14/11 to nursing administration staff regarding nursing staffing data posting requirements. The weekend nursing supervisor will post nursing staffing data at the beginning of the weekend shift. The manager on duty will observe for posting data each day to ensure continued compliance. The manager on duty will report findings each Monday during the management daily meetings three months.	4/5/11

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F 356	Continued From page 14 for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure nurse staffing data was posted on a daily basis, at the beginning of each shift. The findings included: Observation on March 6, 2011, at 9:30 a.m., revealed nurse staffing data was posted in the front lobby of the facility. Continued observation revealed the posted nurse staffing data was dated March 4, 2011. Interview on March 6, 2011, at 10:15 a.m., in the front lobby of the facility, with Licensed Practical Nurse (LPN) #3, confirmed the facility failed to post the nurse staffing data on a daily basis, and had not been updated since March 4, 2011.	F 356	4. The Director of Nursing will report audit results to the Quality Assurance Committee monthly consisting of the Medical Director, Director of Nursing, Administrator, Social Services, Pharmacist and other interdisciplinary team members for further recommendations, if needed. The Administrator will monitor to ensure continued compliance.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. All observations cited of the dietary department were immediately corrected by the dietary department staff at the time of the survey. 2. No other negative observations were found during the rest of the survey.	4/5/11

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F 371	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to maintain the dietary department in a clean and sanitary manner. The findings included: Observation of the Dietary Department on March 6, 2011, at 9:40 a.m., with the Dietary Manager, revealed the following: One plastic bag of ten veggie-burgers were opened without a label or date when opened. One five-pound package of chicken breast fillets, with four pounds remaining, opened with no date opened. One container of Sherbet with no date opened. One and one-half loafs of cooked French toast not labeled or dated. Two small packages of individually wrapped American cheese with no date opened and no original outer package. One half pound of (block) butter opened with no date opened. One half of a five-pound package of Mozzarella cheese with no date opened. One 24-count egg flat, with six eggs remaining in the flat, placed on top of a box/carton of pureed ham, a box/carton of Pepperoni, and a box/carton of sliced ham. Continued observation of the walk-in refrigerator on March 6, 2011, revealed the refrigerator had no thermometer. Continued observation revealed	F 371	3. The Registered Dietician conducted and educational inservice to the dietary staff regarding general sanitation requirements and storage standards requirements on 3/9/11. The Dietary Director will conduct sanitation and storage audits at least five times weekly, including at least one weekend day for four weeks, then at least weekly for three months, then at least monthly thereafter. The Clinical Certified Dietary Manager will conduct at least one random sanitation and storage audit each week for three months. The audit findings will be reviewed with the Administrator at least weekly for three months to ensure continued compliance. 4. The Director of Dietary will report audit results to the Quality Assurance Committee monthly consisting of the Medical Director, Director of Nursing, Administrator, Social Services, Pharmacist and other interdisciplinary team members for further recommendations, if needed. The Administrator will monitor to ensure continued compliance.	

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F 371	Continued From page 16 loose plastic wrap and a whole cantaloupe on the floor. Observation of the walk-in freezer on March 6, 2011, at 9:40 a.m., revealed loose plastic wrap and paper on the floor. Continued observation of the dietary department dry storage on March 6, 2011, at 9:40 a.m., revealed a five-pound bag of flour with three cups remaining, with no date opened, and no expiration date. Continued observation of the dietary department on March 6, 2011, at 9:40 a.m., revealed twenty-eight coffee cups were wet and turned down on a flat, sheet pan. Continued observation revealed twenty-four juice classes were wet and turned down on a flat, sheet pan. Continued observation revealed eight, two-inch serving pans and eight, deep serving pans nested wet. Continued observation of the dietary department on March 6, 2011, at 9:40 a.m., revealed a three drawer plastic silverware caddy, was found soiled and in disrepair (missing wheels); the handles and sides of a clean towel barrel were soiled. Continued observation revealed the flour and cornmeal caddies were soiled around the top opening and covered with plastic wrap which was also soiled. Observation on March 6, 2011, at 9:40 a.m., revealed the reach in refrigerator had debris, and spilled liquids at the bottom ledge of the double doors. Oservation on March 6, 2011, at 9:40 a.m., revealed the convection ovens had baked grease	F 371		

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F 371	Continued From page 17 inside the ovens and food particles and grease on the outside of the ovens at the base of the two double doors. Continued observation on March 6, 2011, at 9:40 a.m., revealed the underside of the lid of the ice machine had a black substance at the two hinges. Interview at this time with the Dietary Manager confirmed the black substance on the ice machine. Review of the Sanitation/Safety/Disaster policy revealed, "...The Director of Food and Nutrition Services develops a cleaning schedule, with assistance from the Registered Dietitian, to ensure that the Food and Nutrition Services department remains clean and sanitary at all times..." Review of the facility's policy for Storage of Cold Food revealed, "...Ambient Temperatures in refrigerators/coolers remain between 34 -38 Degrees Fahrenheit ...Record temperatures at a minimum of twice a day..." Review of the facility's policy for Storage of Cold Foods revealed, "...Eggs in shell remain in their original container and are stored below cooked or ready-to-eat food; Leftovers are dated properly and discarded after 72 hours unless otherwise indicated..." Review of the facility's policy for Dry Storage revealed, "...Opened packages of food are resealed tightly to prevent contamination of the food...Label items with the date delivered. Use it according to the "first in, first out" rule..." Review of the facility's policy for Labeling Food	F 371		

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F 371	Continued From page 18 Items revealed, "...Once the name of the food item is written on the label, the date that the item was opened also is written there...Food items in boxes or packages should be removed and placed in an enclosed container...Frozen food items should be wrapped in plastic wrap and then with foil...Leftover food must be covered securely and labeled with the type of food and the date it is being placed in the refrigerator..." Review of the facility's policy for Washing Pots and Pans revealed, "...Pots and pans should be inverted on the drying counter so they will drain properly..." Interview with the Dietary Manager on March 6, 2011, at 10:30 a.m., in the dietary department, confirmed the facility failed to maintain the dietary department in a sanitary manner and failed to maintain the dietary equipment in good repair.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	1. The nebulizer mask for resident # 21 was properly stored by the nursing staff on 3/6/11. 2. All other residents with nebulizer masks were observed by the nursing administration staff to be in compliance with storage standards on 3/6/11.	4/5/11

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F 441	Continued From page 19 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement infection control measures related to proper storage of a nebulizer mask when not in use for one resident (#21) of twenty-three residents reviewed. The findings included: Resident #21 was admitted to the facility on February 11, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease. Medical record review of a Nurse Practioner's order dated February 15, 2011, revealed the resident was to receive albuterol nebulizer	F 441	3. The Staff Development Director or designee conducted an educational inservice to the nursing staff on 3/15/11 on the Infection Control Polices and Procedures, specifically on proper nebulizer handling and storage. The nursing administration staff will conduct at least five times per week for four weeks, then at least weekly for three months, audits of proper nebulizer handling and storage. The audit results will be reviewed by the Director of Nursing or designee at least weekly for four months. 4. The Director of Nursing will report audit results to the Quality Assurance Committee monthly consisting of the Medical Director, Director of Nursing, Administrator, Social Services, Pharmacist and other interdisciplinary team members for further recommendations, if needed. The Administrator will monitor to ensure continued compliance.	

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F 441	Continued From page 20 (respiratory) treatments every four hours. Observation on March 6, 2011 at 9:40 a.m., revealed a nebulizer mask uncovered and hanging from the bedside lamp in the resident's room. Interview with Registered Nurse #2 on March 6, 2011 at 9:44 a.m., at the resident's bedside, confirmed the nebulizer mask had not been properly housed in it's packaging between respiratory treatments to reduce the risk of infection.	F 441		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory services for one (#23) of twenty-three residents reviewed. The findings included: Resident #23 was admitted to the facility on December 9, 2008, with diagnoses including Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Diabetes, and Depressive Disorder. Medical record review of a physician's order dated February 18, 2011, revealed an order to complete a BNP (diagnostic laboratory report for	F 502	1. The laboratory results for resident # 23 were obtained on 2/20/11. 2. The nursing administration staff reviewed all other residents physician orders for laboratory to ensure all have been completed.	4/5/11

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F 502	Continued From page 21 Congestive Heart Failure) stat (right now). Medical record review revealed no documentation the BNP had been completed. Interview on March 8, 2011, at 10:20 a.m., with the Assistant Director of Nursing, in the conference room, confirmed the stat BNP ordered on February 18, 2011, had not been completed.	F 502	3. The Staff Development Director or designee conducted an educational inservice on 3/15/11 to the nursing staff regarding the importance of obtaining laboratory results in a timely manner. The nursing administration staff will review all laboratory daily orders and will follow-up daily to ensure the laboratory procedure have been completed, at least five times weekly for four weeks, then at least weekly for three months. The results of the reviews and follow-up will be reviewed by the Director of Nursing at least weekly for four months. 4. The Director of Nursing will report audit results to the Quality Assurance Committee monthly consisting of the Medical Director, Director of Nursing, Administrator, Social Services, Pharmacist and other interdisciplinary team members for further recommendations, if needed. The Administrator will monitor to ensure continued compliance.	